# Exhibit 12

07/01/2010 14:26	12488894582	MICHIGAN BILLIN	G	PAGE 40/50
Liniversal Health	ם בארטינים ו	PATIENT R Children He	LUATION MARKET GROUP, INC.	
Patient Name: Redacted  Date: 0 4-39-	-10			
Current Complaints:    V Neck Pain   Type:   Programme   V Mid Back Pain   V M	Toroghus Cin	Frequency: Frequency: Frequency: Frequency:	Difficulty: Skiting Standing Lifting Dending Deshing Pulling Desching Overhead Squatting Kneeling Others:	
Munitie Spasm:  Sub Occipitals  Gérvical Spine Para Spinal  Thoracic Spine Para Spinal  Lumbar Spine Para Spinal  Traps  Lévator Scapula  Quadratious Lumorum  Piriformis  Hamstrings	Palpation Cervical:  Ct	Palpation Thoracic:    T1	Palpation Lumibar:    11	
ERVICAL EXAM				
Neck Spasms   Right   Left   Sult Occipitals Spasm   Depreased Glip Strength   Decreased Muscle Strength   Cervical Compression Test   Shoulder Depression Test   Valuativa's Test   Cervical Distraction Test	R D Shight B - Fretins +	ROM: Pales 1 Minimal 2 Modera  FLEXION  EXTENSION  RIGHT LATERAL FLEXION  RIGHT ROTATION  EFT ROTATION	+ + PARA + 1 + 2-3	

MICHIGAN BILLING

07/01/2010 14:26

Dont Pain \_

12488894582

PAGE 41/50

Re-Evaluation continued page 2 Lumbar Exam Lumbar Spasms . . ROM: Pain\* 1 Minimal 2 Moderate 3 Severe Not tested unions indicated Right Left PAIN Decreased Muscle Strenbth FLEXION Straight Leg Raiser Right EXTENSION Straight Leg Raiser Left RIGHT LATERAL FLEXION Proggard's Test LEFT LASTERAL FLOCION Kennos Test (D) (B)
Patrick Feber Test (D) (B) RIGHT ROTATION LEFT ROTATION Other\_ Other Chest pain Abdominal Pain Head Pain Elbow Pain R Hand Pain R Leg Pain Ř Knee Paln R Ankle Pain R Foot Palin \_\_ Others: Others: Testing / Consultations: Medical podeor Of. Challer MRI (+) 6/5012 C3-67 <u> 23 - 25</u> CT SCAN HESALE CS B CLOSED HEND EVALUATION PHYSICAL THERAPY - PAIN MANAGEMENT - restweet no surgery until 4-6 me-ths See Previous Re-Exam Diagnosis: Cervical Sprain Carried lise displayment Thoracic Sprain Lambar Sprain Hepdaches conjulsion Cerylcal Radiositius Cumbar Radicultus those prin Muscle Spesm(s)

07/01/2010 14:26 12488894582	MICHIGAN BILLING	PAGE 42/50
Re-Evaluation continued		page 3
RG 1780-0		
Treatment Plan	weeks	
Continue current treatment plan 3 time	es a week forweeks	
Moist Heat	•	: ·
Mechanical Traction Deep Tissue Massage Therapy Thoras		
Therapeutic Exercises Cervical Thoras	cic Lumbar	
Adjustments		
Disability		:
Work Household		
Attendant Care times a week, for	ours <sub>i</sub> a dayi	
☐ Driving	€oa)s	
Prognosis	Decrease Pain Increase Strength	
Good Excellent	Increase Range of Motion	92
☐ Guarded	Restore activities of daily Initiation of Independent	Home exercise program
Depend on further treatment Depend on further diagnostic testing	Back to a full time work s	chedula
D Depoint on the same of the s		
Discussion		
- I Communication	week .	
7) Musing Therapy	1 10 10 - 12 - 12 - 12	Pl. Kinkloom
4) Follow up with W	V. Churce, W. Kense,	
		,
1		
		•
	Date: 6	-29-10
Physicians Signature:		
		•
: ,	•	

07/01/2010 14:26 12488894582

MICHIGAN BILLING

PAGE 38/50

1500 HEALTH INSURANCE CLAIM FORM APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE DB/DS	FAX 888-8 PO BOX 23		PICA (TTT)
1. MEDICARE MEDICAID TRICARE CHAMPU (Medicare #) (Modicald #) (Sporsor's SSN) (Member	- HEALTH PLAN - PIR LING V	14 INSURED'S LD, NUMBER 22B130224	(For Program in Item 1)
Redacted	3. PATIENT'S RISTULDATE SEX Redacted F  6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other  8. PATIENT STATUS Single Mentled Other	Redacted	
AND THE PROPERTY HAVE	Employed Full-Time Part-Time Student Student Student 10. IS PATIENT'S CONDITION RELATED TO:		
B. OTHER INSURED'S POLICY OR GROUP NUMBER  D. OTHER INSUREO'S DATE OF BIRTH SEX  MM DD YY  M F  C. EMPLOYER'S MAME OR SCHOOL NAME	a. EMPLOYMENT? (Current or Previous)  YES NO  b. AUTO ACCIDENT?  PLACE (State)  C. OTHER ACCIDENT?	a. INSURED'S DATE OF BIRTH Redacted  a. EMPLOYERS NAME OF SCHOOL  c. INSURANCE PLAN NAME OF PR	M X F 9EX
d. INSURANCE PLAN NAME OR PROGRAM NAME	YES NO	STATE FARM INST	URANCE
12. PATIENTS OR AUTHORIZED PERSON'S SIGNATURE I authorize the n to process this claim. I also indust payment of government bonefits eithe below.  SIGNATURE ON FILE SIGNED	aleast of any medical or other information necessary or to myself or to the party who accepts assignment  06 29 10	13. INSURED'S OR AUTHORIZED PI Payment of medical benefits to the services described below.  SIGNATURE	ERSONS SIGNATURE Lauthorize a undersigned physician or supplier for ON FILE
SIGNATURE ON FILE  SIGNED  14. DATE OF GURRENT:   ILLNESS (First symptom) OR   IS. I   INLNESS (First symptom) OR   INLNESS (First s	NP) 17-000-413-65	16, DATES PATIENT UNABLE TO W FROM MM DD YY  18. HOGPITALIZATION DATES RELA FROM MM DD YY  20. OUTSIDE LAB?  YES NO DOWN ON THE PROPERTY OF TH	
2. 847 1 2. A. DATE(S) OF SERVICE B. C. D. PROCE	722 0 DURES SERVICES OR SUPPLIES E	23. PRIOR AUTHORIZATION NUMBER	ir .
мм ор үү мм ор үү замусс ыма сетинсес ре 29 10 06 29 10 11   99212	IN Unusual Circumstances) DIAGNOSIS S I MODIFIER POINTER	\$ CHARGES ON S	π ID. RENDERING PROVIDER IO #
State Management of the state o			NPI NPI NPI
25. FEDERAL TAX I.O. NUMBER SSN EIN 28. PATIENTS AC 205918486	COUNT NO. 27. ACCEPT ASSIGNMENT?	28. TOTAL CHARGE 28. AM	NPI NPI NPI OUNT PAID JSÖ. BALANCE DUE
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the neverse scope to high bit and are morder a part internet.) FRANCISCO GUTTERREZ  07 01 10	HEALTH GROUP EENFIELD RD #140 MI 48237	150 00 ; 33. BILLING PHOVIDER INFO R PH. I UNIVERSAL HEALTH 5761 W MAPLE RD VEST BLOOMFIELD	0 00   150 00 - 248 9894580   I GROUP
SIGNED DATE 158832-6. NUCC Instruction Manual available at: www.nucc.org	33 6,	1588832653 b.	0000 50 50 000 500 600

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

### REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare caim is made. Sea 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare asynced or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS iscal intermediary as the full charge. and the patient is responsible only for the deductible, consurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare camer or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

#### **BLACK LUNG AND FECA CLAIMS**

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)
I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare of CHAMPUS

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32)

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

## NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by CMS, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411,24(a) and 424.5(a) (6), and 44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by those programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974. 'Republication of Notice of Systems of Records.' Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-30, or as updated and republished

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S). To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment to whom a record pertains. Appropriate disclosures made at the record to whom a record pertains. Appropriate disclosures made at the record to whom a record pertains. the Secretaryon Detense internations; to the internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitioment, cialms adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party kability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the modical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1986", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any talse claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid ONB control number. The valid ONB control number for this information collection is 0938-0999. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CNIS, Attn. PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850. This address is for comments and/or suggestions only. DO NOT WALL COMPLETED CLAIM FORMS TO THIS ADDRESS.

Universal Health Gr	onia 	PAVIENT RE- Universal Hea	LUATION lth Group, Inc.
Patient Name: Reducted  Date: $05-35-1$	2B133549	<u> </u>	
Current Complaints:  Neck Pain Type:  Mid Back Pain Type:  Low Back Pain Type:  R Arm Numbness  Arm Numbness  T Leg Numbness  Upper Extremity Weakness R  tower Extremity Weakness R	7-8/10 Headaches 9-10 Dizziness   Dizziness   Tinnitus   Jaw Pain   Memory Loss   Trouble Sleet   Others:	Frequency: DA / L 7 Frequency: Frequency: Frequency: Frequency: Frequency:	Difficulty: Sitting Standing Lifting Bending Poshing Pulling Keaching, Overhead Squatting Kneeling Others:
Muscle Spasm: Sub Occipitals Cepvical Spine Para Spinal Thoracic Spine Para Spinal Lumbar Spine Para Spinal Traps Levator Scapula Quadratious Lumorum Prinformis Hamstrings	Palpation Cervical: C1 C2 C3 C4 C5 C6 C7	Palpation Thoracic:    71	Palpation Lumbar:  LI L2 L3 L4 L5 Sacrum Right Reum Left Reum
Neck Spasms Right Left Sub Occipitals Spasm Decreased Grip Strength Cervical Compression Test Shoulder Depression Test Soto Hall Test Valsalva's Test Cervical Distraction Test	Y N  Duckst  Duckst  Duckst  Duckst  Duckst  Duckst		LEXION 3-1

Evaluation continued				
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nbar Exam	<u>;                                    </u>	·		
	ir.	ROM: Pain+ 1 Minimal 2 Moderate 3	Comment by several authors in the state	7
Lumbar Spasms Y N		(OM: Pain+ 1 Printed 2 Procedure 2	, Severa and restract house annuality	
Right			+ + PAIN	
Decreased Muscle Strength R	Ì	FLEXION	7 3	
Straight Leg Ralser Right G		EXTENSION	3	
Straight Leg Raiser Left (+) - Braggard's Test (+) -		RIGHT LATERAL FLEXION LEFT LASTERAL FLEXION	1 3	
Kemps Test CLO + -		RIGHT ROTATION	1/2/3	
Patrick Faber Test (L) (4) + -		LEFT ROTATION	3	
Other				
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Chest pain	,			
Abdominal Pain	•			
Head Pain				
Hand Pain R · L				
Leg Pain R L				
Hriee Pain &				
Ankle Pain (R)				
Foot Pain (B) (1)				
Others:				
Others:		,		
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Medical Doctor DR, CHPLE			, 	
MR Land - Sending on	t for our	nren it has		
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CLOSED HEAD EVALUATION	TOPICITORI	et for ities	***************************************	
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PHYSICAL THERAPY				<del></del>
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See Previous Re-Exam				
Diagnosis:			10-11-	E-/
ervical Sprain			Rib-Kreetnes	5-6 er
Thoracic Sprain		- Tour PUL	Far aturn	
Lumbar Sprain		22 Dient	TOE Fractiones	n Rt.
Cervical Radiculitius				
Lumber Radiculitius			~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~	
Lumber Radiculitius  Muscle Spasm(s)  Joint Pain BLAT Knews E	ZAOW'S, ANI			

Re-Evaluation continued	page 3
Treatment Plan	
Continue current treatment plan times a week   Moist Heat Lice	for weeks.
☐ Mechanical Traction ☐ Deep Tissue Massage Therapy ☐ Therapeutic Exercises Cervical Thoracic Lum ☐ Adjustments ☐ ☐ ☐ ☐	nbar
Disability  Work Household Attendant Care Driving  Driving	
Good Guarded Poor Depend on further treatment	Decrease Pain Increase Strength Increase Range of Motion Restore activities of daily living Initiation of Independent home exercise program Back to a full time work schedule
Discussion  1) Cont. TX, Plan  2) Follow up DR,  Hosp. DR TOC  MR F'S Nort  3/ Home ISS/145	CHUPLON, Petroit Rossing it , and Sending out for GT,L Visit
Physicians Signature: (e )	Date: 5/25/10

STATE FARM INSURANCE 15000. BOX 2361	
HEALPHONUSTANUE CLAREFORM	
PPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05	PIGA [*** T
MEDICARE MEDICAID TRICARE CHAMPUS GROUP FECA OTHER HEALTH PLAN BUX LUNG (R)	1a. INSURED'S I.D. NUMBER (For Program in Item 1)
(Medicare #) (Medicald #) (Sportsor's SSN) (Member ID-X (SSN or ID) (SSN) (ID)	22B133548
edacted 3 Redacted TX FC	Redacted
6. PATIENT RELATIONSHIP TO INSURED	<del>-    </del>
Set Spouse Child Other  8. PATIENT STATUS	1
Single X Married Other	
Fut-Time Part-Time	
Employed   Student   Student   Student   Student   10. IS PATIENT'S CONDITION RELATED TO:	+
a. EMPLOYMENT? (Current or Previous)	H
YES XNO	
OTHER INSURED'S DATE OF BIRTH SEX b. AUTO ACCIDENT? PLACE (State)  MM   DD   YES   X   NO	b. EMPLOYER'S NAME OR SCHOOL NAME
. EMPLOYER'S NAME OR SCHOOL NAME . C. OTHER ACCIDENT?	c. INSURANCE PLAN NAME OR PROGRAM NAME STATE FARM INSURANCE
YES X NO YES X NO 10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
	YES YES If yes, return to and complete item 9 a-d.
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 2. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to mysel or to the party who accepts assignment.	<ol> <li>INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.</li> </ol>
bsow.	SIGNATURE ON FILE
SIGNATURE ON FILE DATE 06 09 2010  4. DATE OF CURRENT: 4 ILLNESS (First symptom) OR 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS	. 18. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
MM DD YY (MULIFY (Academ) OR GIVE FIRST DATE MM 20 2010	FROM TO TO
7. NAME OF REFERRING PROVIDER OF OTHER SOURCE 178.	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES WM DD YY MM DD YY TO
9. RESERVED FOR LOCAL USE	20. OUTSIDE LAB? S CHARGES  YES (X) NO ( )
1. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate Items 1,2,3 or 4 to Item 24E by Line)	22. MEDICATO RESUBMISSION ORIGINAL REF. NO.
3. <u>1847.2</u>	23. PRIOR AUTHORIZATION NUMBER
847 1	EG. FORM ACHION ISOMOCO
A.A. DATE(S) OF SERVICE B. C. D. PROCEDURES, SERVICES, OR SUPPLIES E. From To PLACE OF (Explain Urussual Circumstances) DIAGNOSI AM DD YY MA DO YY SERVICE EMG CPT/HCPCS ( MODIFIER POINTER	
AM DD YY MA DO YY SERVELENG CPTHCPCS   MODERN   POINTER  05 25:10   05 25:10   11   99212   ! ! ! 1	150.00   1   NPI 1104973007
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S. FEDERAL TAX I.D. NUMBER SSN EIN 28. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT?	28. TOTAL CHARGE 29. AMOUNT PAID 30. BALANCE DUE
05918486 F PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS	33. BILLIA GAR INFO & PH. (0.00) 7 260.00
(I centify that the statements on the reverse units bid and are made a part thereof.)	UNIVERSAL HEALTH GROUP, INC. 5761 WEST MAPLE ROAD
	ALAL MEDI HIMCET HOUR
DAVID KATZ 26561 W. 12 MILE ROAD SOUTHFIELD MI 48034 DATE 1588832653 D. 1588832653	WEST BLOOMFIELD MI 248 626 6893

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS

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#### BLACK LUNG AND FECA CLAIMS

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FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S). To evaluate eligibility for med call care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitioment, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party kability, coordination of benefits and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in detay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the mudical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claims under these programs. payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

## MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OWB control number. The valid OWB control number for this information collection is 9938-9999. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn. PRA Reports Clearance Officer. 7500 Security Boulevard, Baltimore, Maryland 21244-1850. This address is for comments and/or suggestions only. DO NOT WAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.

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Universal Health Gr	<b>a.</b> a.			
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Date: 8-9-10				
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Therapeutic Exercises Cervical Thoracic Lumbar  Adjustments
Work Household Attendant Care times a week, for hours a day Driving
Progress Geals
☐ Excellent       ☐ Decrease Pain         ☐ Good       ☐ Increase Strength         ☐ Guarded       ☐ Increase Range of Motion         ☐ Poof       ☐ Restore activities of daily living         ☐ Depend on further treatment       ☐ Initiation of Independent home exercise program         ☐ Depend on further diagnostic testing       ☐ Back to a full time work schedule
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Physicians Signature: LAMC Date: 8-9-10

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SIGNATURE ON FILE	12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of they medical or other information necessary to proceed this claim. I also request payment of government benefits either to myself or to the party who accepts assignment	19. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for salvices described below.
T220 72210 72211 7231 7241 7242   YES   X NO	SIGNATURE ON FILE 08 09 10	SIGNATURE ON FILE
T220 72210 72211 7231 7241 7242   YES   X NO	14. DATE OF CURRENT:    ILLNESS (First symptom) OR   15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM   DD   YY   YY   YY   YY   YY   YY	IPHOM I I TO I I I I
T220 72210 72211 7231 7241 7242   YES   X NO	17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 17a. 170.0021365	
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BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAWS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS

NOTICE: Any person who knowingly flies a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

### REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a medicare claim, the patient's signature authorizes any entity to release to medicare medical and nonmedical information, including employment status, and whether the person has employer group health Insurance, liability, no-lault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare caim is made. See 42 Instituted, liability, no-rabit, vorter's completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sportsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

#### BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)
I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the United Scruces or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32)

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and Imprisonment under applicable Federal laws.

#### NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by CMS, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411,24(a) and 424.5(a) (6), and 44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by those programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, hoalth plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disc ose information about the benefits you have used to a hospital or doctor. Additional disc osuros are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, "Carrier Medicare Claims Record," published in the Federal Rogister, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974. 'Republication of Notice of Systems of Records.' Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished

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SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

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DATE: SALVA	HUTI
	0.23-56
Redacted Universal Health Grou Redacted PATIENT NAME LAST:	
SUBJECTIVE: SEVERITY SCALE 1-10 (EXCRUCIATING) Type of complaint: L=left R=right W=weekness N=numbness T=A=schy D=dull B=burning C=constant F=frequent O=cocssionally	-tingling S=sharp
4/n NEDS ARM LEG ELBOW ALA	LEADACHE
3/0 SED BACK SHOULDER HIP ANKLE C/ D COWBACK WRIST KNEE CHEST BUTTOCK HAND FOOT ABDOMEN	_ DIZZINESS _ MEMORY LOSS _ SLEEP DIST.
NOTES:	
Of state of the @ tall / (50) to Old	
OBJECTIVE: POSTURE/GAIT: NORMAL NOTE:	***
PALPATION FINDINGS: L=left R=right T=tenderness S=spasm  L R	is
NOTES:	-
ASSESSMENT: First visit Guarded Continue - no change As expected Exacerbation of condition	
☐ Mild improvement ☐ Moderate improvement ☐ Other:	
Adjustment: OCC/C1/C2/C3/C4/C5/C8/C7/T1/T2/T3/T4/T5/T6/T7/T8/T9/T10/T11/T12/L1/L2/L3/L4/L5/S/RSI/LSI	
Extra Spigal: L/R shoulder L/R elbow L/R wrist L/R hand L/R knee L/R ankle foot Other:	
NOTES:	
PROGRESS/TREATMENT PLAN: Goals: reduce symptoms, increase functional capacity and return to normal activities of daily	· living
THERAPEUTIC Plase 1: Acute Inflammatory, reduce inflammation, muscle spasm and pain	
☐ THERAPEUTIC PHASE 2: Repair and remobilization: functional scar formed and increase pain-free ROM	
THERAPEUTIC PHASE 3: Remodeling and rehab: Increase coordination, strength, ROM, endurance and work capacity	
Tx schedule:   daily   3x/wk   2x/wk   1x/wk   2 wks   3 wks   monthly   cont. Tx plan   Massage:   0   1	] 2 per wk/mo
Tx schedule:	2 per wk/mo
NOTES:	2 per wk/mo
NOTES:	· ·
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Redacted Patient Name (last)	Liniversell-l	redacted	Age:	Male [] Fernal
☐ initial exern ☐ Re-exern				
Height:B	Paipation: WNL		Spinal Pa	
Blood Pressure:	<ul> <li>Skin, temperature, moisture:</li> <li>Parotids, thyroid, lymph nod</li> </ul>	98:		
Posture:	All and the state of the state			<u>*                                      </u>
Ge/t:	and and deleted as	Hai	<del></del>	2
Skin (bruising, scars):		(011/m)		<del>-</del> <del>-</del> -
Sensation DNP I. R	D externe (e)			
Light touch	U MFTP (X)		C7.	
Sharp/dull	D ache (a)		T1.	·
	Li burning (h)		73 T3	
Vibration	10000000000000000000000000000000000000			<del>*************************************</del>
Reflexes (0.5) ONP L R		The same of		×
Biceps (C5)(musculocutaneous)			T7.	
Brachioradialis (C6)(redial)		MAN NI STOP		
Triceps (C7)(radial)			710	<u> </u>
Patellar (L4)(femoral)			/ T11	
Medial hamstring(LS)(sciatic)	1 17171	\ <u>\</u> \\\\\\	/T12	<b></b>
Achilles (S1)(tibial)			12	
Babinski		(1041/140)	L3	
Other:	\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	\WI)(III)	3 (4)	<del>\ \ \ \</del>
CHI WNL	I WWW	\W\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	<u>X</u>	
Headaches Dizzy				
Blarred vision Sleep disturbance	<b>6999</b>		SI	
Tinnitus Neusea/vomiting Photosensitivity				
[ (derpent source of [ ] supremental	Orthopodic exam:	NANT DOMES		<del></del> 1
Mator (0-5) DNP L R	Carlo CND	Ossissa Mari		
Resisted neck ROM (CI-C4) 5 5	Functional DNP + -	Cervical in WNL L R	Lumbar & WML	L R
Shoulder elevation (CN XI, C3-C6) 1		Compression 4	Kempla test	<b>4</b>
Shoulder abduction (C4-C6)	Toe walk (S1)	Macdimed compression 49 6	SLR passive, active	<b>6 (9</b>
Elbow flexion (C5-C6)	Tendam Romberg	Distraction	Breggard's	9 0
	Romberg	PROM	Patrick's (FABERE)	<b>9 9</b>
Elbow extension (C5-C8)	Other:	Shoulder Depressor (4) (6)	Thomas/Gaensien's	Q 69
Wrist/finger flexion (C7-T1)	h	Soto Hall/Brudzinski	Valsalva	95/100
Wrist/finger extension (C6-C8)		Flexion (45°) WH		
Hip flexion (L1-L3)		Extension (55°)	SI distraction/compression	₩ ₩
Knee extension (L2-L4)		Leteral flexion (45")	Flexion (90°)	WAL PI
Knee flexion (L4-S1)				<del>                                     </del>
Plantar flexion (L5-S2)		Rotation (70")	Extension (30°)	
Dorsiflexion (L4-L5)		Alt. He	Leteral flexion (20*)	
Other:		Of Lyone	Rotation (30")	1/1/
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/	11 11		#	Jensel Hills
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Doctor: Sell N. Miller Doc	Doctor(prir	nted): Scott A. Witinf	Date: 5/	31/12
UHG-DET	PHYSICA	AL EXAM	/	U1;

HEALTH INSURANCE CLAIM FORM APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05	STATE FAR PO BOX 66 DALLAS TX	75266	
1. MEDICARE MEDICAID TRICARE CHAMPUS  (Medicare #) (Medicaid #) (Sponsor's SSN) (Membe	r (D#) (SSN or (D) (SSN) X (ID)	1a. INSUREO'S I.D. NUMBER (For Program in Item 1) 118070161	
Redacted	S. PATIENT'S BIRTH DATE  SEX  Redacted X F  6. PATIENT RELATIONSHIP TO INSURED  Set X Spouse Chil Other  8. PATIENT STATUS  Single Married X Other	4. INSURED'S NAME (Lest Name, First Name, Middle Initial) Redacted	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
a. OTHER INSURED'S POLICY OR GROUP NUMBER  b. OTHER INSURED'S DATE OF BIRTH SEX  M.M.   DO   YY   M   F	Employed Student Student Student Student Student 10. IS PATIENT'S CONDITION RELATED TO:  a. EMPLOYMENT? (Current or Previous)  YES X NO  b. AUTO ACCIDENT? PLACE (State)  X YES NO MI	b. EMPLOYER'S NAME OR SCHOOL NAME	1
c. EMPLOYER'S NAME OR SCHOOL NAME  d. INSURANCE PLAN NAME OR PROGRAM NAME	c. OTHER ACCIDENT?  YES X NO  10d. RESERVED FOR LOCAL USE	c. INSURANCE PLAN NAME OR PROGRAM NAME STATE FARM INSURANCE d. IS THERE ANOTHER HEALTH BENEFIT PLAN?  YES [X] NO # yes, return to and complete item 9 a-d.	<del>-</del>
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE   authorize the to process this claim. I also request payment of government benefits e below.  SIGNATURE ON FILE  SIGNED  14. DATE OF CURRENT:   ILINESS (First symptom) OR   10   0   0   11   11   11   11   11	s release of any medical or other information necessary	13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.  SIGNATURE ON FILE  SIGNED	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE SCOTT WITINKO DC 1  19. RESERVED FOR LOCAL USE 72291 72292 72293 7241 7242 7  21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate Items 1, 739, 1	3 _ 739 3 🔻	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM DD YY  16. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM DD YY  10. OUTSIDE LAB?  YES X NO 0 0 0 0  22. MEDICAID RESUBMISSION ORIGINAL REF. NO.  23. PRIOR AUTHORIZATION NUMBER	
2 T 3 9 2  24. A. DATE(S) OF SERVICE From To PLACE OF (E) MM DD YY MM DD YY SERVICE EMG CPT/M	4. 739 4  CCEDURES, SERVICES, OR SUPPLIES E. DIAGNOSIS  CPCS   MODIFIER POINTER	F. G. H. I. J.  DAYS PSOT ID. RENDERING ON PROVIDER ID. #	
05 31 12   05 31 12   11   992	13	200 00   1   NPI 1447449905	
		NPI NPI	
		NPI NPI	
205918486 [X] 39630 31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS UNIVER		NPI  28 TOTAL CHARGE 29. AMOUNT PAID 30. BALANCE DUE 200 00 00 200 00 33. BILLING PROVIDER INFO & PH. # (24878894580)  UNIVERSAL HEALTH GROUP 2000 TOWN CENTER SUITE 625 201 SOUTHFIELD MI 48075 1135 201  a.1588832653 b.	0

BECAUSE THIS FORL IS USED BY VARIOUS GOVERNMENT AND PRIVATE REALTH PROGRAMS, SEE SEPARATE INSTITUTION OF ISSUITS BY APPLICABLE PROGRAMS.

NOTICE: Any paraonisation another; y face a later of the containing any microgreporatelles or my falso, incomplished an influence of a fact most on may be guilty of a criminal collection of penishable under later of may be subject to civil pensities.

#### VALUE CLARGORY VAST, KREVOS OV SOLFESK

MEDICARE AND CHAMPUS PAYOUTHS. A particing on account flow only recent be made and authorized release of any information account by process. the claim and continue to at the information provided in Block. I through 12 is true, accurate and complete. In the case of a Medical rate of the first authorizes any ontay to release to the number and incoming a number of the policy of the policy of the insurance, liablity, no fault, worker's compensation or other insurance which is responsible to pay for the services for which he filled an electric of the insurance, liablity, no fault, worker's compensation or other insurance which is responsible to pay for the services for which he filled and electric of the information to the health plan or a gency shown in A arriver serviced or CHAMPUS participation case. The physican express to recent the critical deturnment on of the Medicare carrier or CHAMPUS flace inflam, clinical charge. and the patent is responsed only to, the addictions, or clurary, and nancovered services. Consumerce and the deduction has being upon the charge determination of the Modicard carner or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a result insurance program but makes payment for health bandits provided through certain of list one with the Uniformed Services. Information on the patient's spontar should be provided in those items each angle in Tinsured 1.10, item. 18, 4, 6, 7, 9, end 11

#### BLACK LONG AND FECA CLARES

The provider agrees to accept the amount paid by the Government ou beginnent in full. See Biber Lung and FECA instructions regime on rule precedure and diagnos s coalng systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CMARCHUS, FECA AND DEACH LUNC)

Leartify that the services shown on this form were medically indirected and these is easy for the health of the patent and were personally furnished by moler were furnished. incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Micro cure or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, aithough incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employed) who rendered invitation active duty member of the Uniformed Service, or a civitien employee of the United States Government or a contract employee of the United States Government, a their civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as repuired by existing law and regulations (42 CFR 424 32).

NOTICE: Any one who misropresents or falsifies essential information to rock the payment from Federal funds requested by this form may upon conviction by subject to fine and imprisonment under applicable Federal laws.

## notice to payient about the collection and use of il elicabe, beech, and black lung information (PRIVACY ACT STATEMENT)

We are authorized by CMS, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicard, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(c) and 424.5(a) (6), and 44 USC 3101;41 CFR 101 et seq and 10 USC 10/9 and 1086; 5 USC 8101 ct seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carners, intermedianes, medical review boards, health plans, and other organizations or Foderal agencies, for the effective administration of Federal provisions that require other third part as payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the bancfits you have used to a hospital or dector. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, Carner Medicare Claims Record, published in the Foderal Register, Vol. 55 No. 177, page 37549, Wed. Sopt. 12, 1990, or as updated and repub shed

FOR ONCE CLARAS: Department of Labor, Privacy Act of 1974, 'Republication of Notice of Systems of Records," Eggette Reporter Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies recoved are authorized by law

ROUTINE (ISF(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept of Jurilies for representation of the Secretary of Defenue in civil actions; to the Internal Revenue Service, privile cellular and consumer reporting agentics in connection with recompressional Cities in response to Inquiries made at the request of the privile to whom a record partains. Appropriate dute occurs may be made to other federal, stato, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality essurence, peer review, organization for by, faird-party liability, coordination of banef to, and civil and criminal litigation related to the operation of CHALLIPUS.

DISCLOSUBES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to rupply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is respond big for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to venily information by way of computer matches.

## MEDICAID PAY...ERTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX pt in and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

Hurther agree to accept, as payment in full, the amount paid of the Madicald program for those claims submitted for payment under fill at program to the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PRYSICIAN (OR SUPPLIER); I carbly that the services luted above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction

NOTICE: This is to curtify that the forceoing information is true, accurate and complete. I understand that payment and satisfaction of this claim wall be from Federal and State funds, and that any false d'ums, cluttersents, or documents, or concentration of a maturial fact, may be prosecuted under applicable. Flourel or State (1996)

According to the Paperwork Reduction Act of 1995 ind exceeds are required to revorable a collection of information unless it displays a valid DWB control number. The imit of control number line to information and section of information unless it displays a valid DWB control number. The imit of control number line to information unless it displays a valid DWB control number. The imit of control number line in information unless it displays a valid DWB control number. The imit of control number line information unless it displays a valid DWB control number. The imit of control number line information unless it displays a valid DWB control number. The imit of control number line information unless it displays a valid DWB control number. The imit of control number line information unless it displays a valid DWB control number. The imit of control number line information unless it displays a valid DWB control number. The imit of control number line information unless it displays a valid DWB control number. The imit of control number line information unless it displays a valid DWB control number. The imit of control number line information unless it displays a valid DWB control number. The imit of control number line information unless it displays a valid DWB control number. The imit of control number line information unless it displays a valid DWB control number. The imit of control number line information unless it displays a valid DWB control number. The imit of control number line information unless it displays a valid DWB control number. The imit of control number line information unless it displays a valid DWB control number. The imit of control number line information unless it displays a valid DWB control number. The imit of control number line information collection is displayed and control number. The imit of control number line information collection is displayed and control number. The imit of control number line information collection is displayed and control number. The imit of control number line infor